Perinatal Needs of Pregnant, Incarcerated Women

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ABSTRACT

Pregnant prisoners have health-care needs that are minimally met by prison systems. Many of these mothers have high-risk pregnancies due to the economic and social problems that led them to be incarcerated: poverty, lack of education, inadequate health care, and substance abuse. Lamaze educators and doulas have the opportunity to replicate model programs that provide these women and their children with support, information, and empowering affirmation that improve parenting outcomes and decrease recidivism.

Journal of Perinatal Education, *17*(2), 37–44, doi: 10.1624/105812408X298372
Keywords: pregnant, incarcerated, childbirth education, doula support

Recent news stories about pregnant prisoners laboring in shackles highlighted once again the special needs of incarcerated women and the consequences to society of not meeting their unique needs. Unlike prison systems in Finland, where the loss of freedom entailed by a prison sentence is considered the major punishment (Roth, 2004), prison conditions in the United States are often punitive and replicate the same societal misbehaviors the system is trying to eradicate. Health risks and physical violations in prisons are unfair and extreme punishments that no one should have to endure (Roth, 2004). Incarcerated women's labor and birth experiences do not even begin to approach the conditions described in Lamaze International's (2007) Six Care Practices That Support Normal Birth, and the lack of screening and appropriate medical treatment leaves these women and their babies at risk for lifelong health problems.

Although women comprise only about 10% of the overall imprisoned population in the United States, they represent the fastest growing population within jails and prisons (Fearn & Parker, 2004; Harrison & Beck, 2004; LaLonde & George, 2002). One reason for this increase is the closing of mental hospitals in the 1970s, giving rise to jails as one of the alternative institutions for mentally ill persons (Mullen, Cummins, Velasquez, von Sternberg, & Carvajal, 2003). In 2003, the number of women in state or federal prisons increased 3.6%, while the number of male prisoners increased 2.0% (Harrison & Beck, 2004). Since 1995, the annual increase in female inmates averaged 5.0%, higher than the 3.3% increase in male inmates (Harrison & Beck, 2004). More than two thirds of imprisoned women have children under the age of 18 years old (Harrison & Beck, 2004). Approximately 6% of these women are pregnant at the time of arrest (Fearn & Parker, 2004; Harrison & Beck, 2004; LaLonde & George, 2002; Martin, Kim, Kupper, Meyer, & Hays, 1997).

Jail and prison conditions operate on gender-neutral policies that have a negative impact on the mental and physical health of women prisoners.

Because of the small population of female prisoners, women are often housed in a single prison at a great distance from family and loved ones. The relatively small number of incarcerated women is used to justify providing fewer rehabilitative and health-care programs. The programs women do receive are often recycled from male facilities and fail to address women's needs (Fearn & Parker, 2004).

Strict, mandatory sentencing laws passed by Congress fail to take into account that mothers and fathers who become incarcerated face different circumstances. Ninety percent of incarcerated fathers report that their children live with the children's mother, while only 28% of incarcerated mothers report their children live with the father during the mother's incarceration (Mumola, 2000). Forty percent of fathers and 60% of mothers in state prison report weekly contact with their children (Mumola, 2000). Their contact is more often by mail or phone than in person, especially when female inmates are incarcerated in special facilities located farther away from their families than facilities are for male inmates. Incarcerated mothers are in worse economic circumstances than either incarcerated men or other economically disadvantaged women. Mothers in state prison are twice as likely as fathers (18% vs. 8%) to report a period of homelessness in the year prior to admission (Mumola, 2000). Imprisonment, especially of women, destroys the family network. When men go to prison, potential role models are lost. When women go to prison, families most often fall apart (Understanding Prison Health Care, 2002).

Women in prison differ significantly from their male counterparts in the reasons for their incarcerations. Women's crimes are less likely to be violent offenses and more likely to involve alcohol, drugs, and property offenses. Women are seldom major drug dealers or traffickers and, when they do commit a violent offense, it is most often against a man who abused them and, so, they rarely pose a violent threat to the general public (Covington, 2000). Poverty and addiction appear to frequently motivate criminal acts by women (Baldwin & Jones, 2000). Males are more likely to use drugs for the excitement, but females are more likely to use drugs to medicate the pain of abusive histories and/or to obtain a relationship (Covington, 2000).

With the growing number of incarcerated women who are pregnant, it is important to recognize that failing to provide preventive and curative health care for these women may cost more to society than funding programs that might improve attachment and parenting behaviors, facilitate drug rehabilitation, and reduce recidivism among this population. The current prison system increases victimization, learned helplessness, passivity, shame, and violation of human rights (Covington, 2000). Posttraumatic stress is elevated by strip-and-cavity searches, handcuffs and shackles, confinement to small cells, isolation, and control by predominantly male staff (Covington, 2000; Johnsen, 2006). Incarcerated women endure further damage and retraumatization with the lack of privacy in a patriarchal system that constantly observes them in their sleep and personal care and with separation from their children (Covington, 2000). According to Baldwin and Jones (2000), the vast majority of incarcerated women have abused alcohol and/or drugs; yet, prison systems are deficient in providing therapy for any addictions. Additionally, Baldwin and Jones (2000) report that pregnant inmates lack adequate prenatal care offering medical, nutritional, educational, environmental, and family-support services. When birth takes place in prison, separation of mother and child occurs almost immediately, which further compromises a critical bonding period (Baldwin & Jones, 2000).

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THE NEED FOR EFFECTIVE BIRTH EDUCATION AND SUPPORT FOR INCARCERATED WOMEN

> *Anna (not her real name)...spent the last two weeks of her pregnancy in preterm labor, shackled to a hospital bed. If she needed to use the bathroom, or even turn over, she had to beg permission of the officer on duty. Given these strict security arrangements, you might assume that Anna was a...hardened criminal at risk for escape. No. Anna is a minimum-security prisoner currently serving an approximately 18-month sentence for drug possession and probation violation....* (Waldman, 2005, 1st paragraph)

As illustrated above and when compared to most expectant and new mothers, incarcerated women

have many more challenges to overcome in dealing with their pregnancies and their birth experiences, developing into motherhood, and providing adequate parenting to their children. Their pregnancies are often considered high-risk events complicated by drug and alcohol abuse, smoking, and sexually transmitted infection (Baldwin & Jones, 2000; Covington, 2000; Fearn & Parker, 2004; LaLonde & George, 2002). Combined with poor social supports and histories of abuse, incarcerated women and their children are at greater risk than most expectant mothers for increased perinatal and postnatal morbidity and mortality (Understanding Prison Health Care, 2002).

On the other hand, incarceration provides pregnant women with shelter they might not have outside of imprisonment. In jail or prison, they are protected from homelessness, malnutrition, and substance abuse; they are housed, fed, and clothed. Many women are also separated from their abusive partners and their access to alcohol, cigarettes, and recreational drugs (P. Spry, personal communication, July 31, 2006). In fact, some women have reported they actually violated their terms of probation when they found out they were pregnant so they would be incarcerated and, thus, be able to protect their babies (P. Spry, personal communication, July 31, 2006).

Prisons are not mandated to provide physical or mental health services to inmates and are not subject to external review. No organizations assess quality of care or set standards of care for inmates. Most prison health-care systems function independently, have no checks and balances, and are isolated from the outside medical community (Understanding Prison Health Care, 2002).

Pamela Spry, a certified nurse-midwife who works with the Colorado Department of Corrections, recently reported that different places of incarceration offer various levels of care (P. Spry, personal communication, July 31, 2006). Spry noted that county and city jails often house inmates awaiting trial and serving time for offenses such as traffic violations and shoplifting. If jails are located in small rural areas, prenatal care may not be available. However, the state systems, which include state and federal prisons within the department of corrections, often have well-established programs for health care. For example, according to Spry, the Colorado Department of Corrections provides nurse-midwifery care to pregnant inmates in the state prison system (not in jails). These incarcerated women also receive onsite prenatal care and are allowed visits to specialty clinics for conditions such as diabetes, repeated pregnancy losses, or preterm births. They are offered genetic amniocentesis (for expectant mothers aged 35 years and older), given surgical repairs for incompetent cervix, and receive standard care for labor and birth (P. Spry, personal communication, July 31, 2006).

In an effort to promote improved health care for imprisoned women, the National Commission on Correctional Health Care (1994) adopted a position statement recommending the need to view incarcerated women as a special population and to provide appropriate treatment. Included in its statement, the commission recommended screening, health assessment, nutrition guidelines and medical diets, pregnancy counseling, and comprehensive services for incarcerated women's unique health problems to be provided in prisons, jails, and juvenile detention and confinement facilities.

Later, Amnesty International (1999a) published '' 'Not Part of My Sentence' – Violations of the Human Rights of Women in Custody,'' which outlines a number of alarming procedures and inadequate health-care practices for women in U.S. jails and prisons. Amnesty International (1999a, 1999b) also reported that unnecessary restraints are routinely used on incarcerated, pregnant women in transport and during medical care. Consequently, Amnesty International (1999a) recommended international standards restricting the use of restraints to situations when they are strictly necessary (e.g., to prevent female prisoners from escaping, from injuring themselves or others, and from damaging property).

In 2000, Baldwin and Jones recommended public health agencies and maternal and child health professionals contribute to the system of health care for incarcerated women in the following ways:

- perform needs assessment of the health of incarcerated women;
- offer prevention programming and primary health-care services (e.g., fitness activities, family planning, and health education);
- provide screening and diagnosis services and treatment (e.g., screening and treatment for sexually transmitted diseases, for smoking cessation, and for pregnancy care); and
- provide health service, professional standards, and quality assurance.

MODEL PREGNANCY AND BIRTH PROGRAMS FOR INCARCERATED WOMEN

Pregnancy and giving birth is a transformational time in a woman's life. With adequate support and prenatal care, expectant and new mothers often discard lifestyle behaviors such as smoking and drinking alcohol that would negatively affect their babies. They eat more nutritious foods, alter their social lives to get appropriate sleep, and exercise more regularly, decreasing their risks of physical complications and depression. With education and support, preparation for birth gives women the opportunity, in this most teachable moment, to change their lifestyle behaviors and to have positive birth experiences that allow them to transform into attached mothers.

To help incarcerated women achieve the same beneficial pregnancy and birth experience described above, model programs have been initiated to provide physical and mental health care to imprisoned women and, on a few occasions, to their infants. In some facilities, mothers and infants are not separated, and women receive counseling, parenting instruction, job-skills education, and appropriate health care. These model programs, some of which are described below, often depend on volunteers, grant monies, community organizations, medical organizations, religious institutions, and university programs to provide financial and staff support.

Doula Birth-Support Program

In their study, Schroeder and Bell (2005) provided a doula birth program for incarcerated pregnant women. The primary and backup doulas met each woman in jail prior to birth to review birth expectations; assess knowledge of labor, birth, and pain management; provide teaching; and develop a plan for participation in labor. The doula then met the woman at the hospital and provided continuous emotional and physical support during labor and birth, took pictures of the birth, and wrote a short birth story. The birth story affirmed the mother's strengths and included details such as her first words to her infant and the ways the infant responded to the mother's touch and voice. After birth, the doula contacted the hospital social worker to follow details of infant placement. The doula made a third visit to the woman (usually within 3 days postpartum) to review the birth experience, provide information about infant placement, and present the photographs and birth story.

Schroeder and Bell's (2005) ongoing multiagency doula project provides continuous emotional and physical support for pregnant women in urban jails located in King County, Washington. Staff members of the Pacific Association for Labor Support, Seattle King County Public Health and King County Jail Health Services, King County Correctional Facilities, and the University of Washington Medical Center developed a procedures manual, a 2-hour correctional facility orientation, and 16 hours of specific training that addresses the birthing hospital's routines, the foster care system, addiction, pregnancy and labor, past sexual abuse, caring for diverse populations, and relevant policies from each of the partner agencies. The doulas involved in the project are experienced and in private practice. Nurses at the jail offer doula services to all pregnant women expecting to be incarcerated at the time of birth. So far, no one has refused the service. Follow-up surveys have indicated overwhelming satisfaction with the program and, although postpartum separation from their infants left them grieving, most of the women actively planned for the future (Schroeder & Bell, 2005).

Camp Share Program

Idaho's Camp Share Program is a 1-week program at the Pocatello Women's Correctional Center for eligible incarcerated mothers and their children (Office of Performance Evaluations, Idaho State Legislature, 2003). As part of the program, mothers and children participate in counseling and planned recreational activities throughout the day. In the evenings, children take part in activities coordinated by community members and spend the night in a local community center.

Women and Infants at Risk Program

In Detroit, Michigan, the Women and Infants at Risk (WIAR) program provides a comprehensive residential program for pregnant, drug-dependent women in the Michigan State adult corrections system. Program goals are the following:

> *. . .to increase the availability of substance abuse prevention and treatment services to pregnant and postpartum women offenders, to reduce the severity and effect of drug exposure to the infants, to reduce the likelihood of relapse and recidivism among the mothers and to promote community awareness of the needs of pregnant prisoners and their infants and facilitate coordination among*

relevant state and local agencies to improve services to them. (Siefert & Pimlott, 2001, p. 129)

The WIAR program was developed by social work students who conducted focus groups and determined that the primary needs of pregnant, incarcerated women were intensive prenatal care (including social support and health education) and comprehensive substance-abuse treatment (Siefert & Pimlott, 2001). When eligibility is established, the pregnant prisoner is transported to the WIAR site where she is directed to a room that has been attractively painted, carpeted, and furnished with a baby crib and dressing table. Appropriate maternity clothing is provided, as well as pregnancy and postpartum informational booklets. The nurse-midwife on the site provides informal instructional classes, bonding with the women, and prenatal care. Women are signed up for Medicaid, and the Medicaid-sponsored multidisciplinary team (including social worker, nurse, and nutritionist) provides assistance with multiple needs, including well-baby visits, housing, and menu planning. Women are treated with respect and dignity, and the program staff plan baby showers for each woman. With the onset of labor, WIAR program staff take the mother to a birthing room at a local hospital where she is joined by her nurse-midwife and her selected labor coach. After discharge from the hospital, mother and baby are housed in WIAR's special bonding room, where they remain for the first month.

According to Siefert and Pimlott (2001), a review of medical and agency records of 45 WIAR program infants indicated they were all born drug free, no fetal or neonatal deaths occurred, and only one infant required admission to neonatal intensive care. Preliminary findings indicated that relapse and recidivism among WIAR program participants after release continued to be a problem, but less so than for prisoners who did not participate in WIAR (Siefert & Pimlott, 2001).

Doula Program for Incarcerated Women

The Cook County, Chicago, Illinois, Bureau of Health Services began the Doula Program for Incarcerated Women in 2001 (Inoue, 2003). The target population is women who are likely to give birth while incarcerated in the Cook County Jail. Doulas are trained to provide physical, emotional, and informational support to these women during pregnancy, birth, and postpartum. The doulas then proceed to provide incarcerated women with prenatal education, continuous support throughout the entire labor and birth, and daily postpartum hospital visits. Follow-up statistics of the program's first year revealed 50 women received doula care, with a cesarean rate of 4% (compared to a hospital rate of 26.95%) and an epidural rate of 33% (compared to a hospital rate of approximately 50%) (Inoue, 2003).

Residential Parenting Program

Washington State's Residential Parenting Program provides a program to keep incarcerated mothers and their babies together in a safe and secure environment (Fearn & Parker, 2004). The program offers mothers the opportunity to bond with their infants and gain the necessary parenting and childhood-development skills through education and external support systems for a successful transition back into the community (Fearn & Parker, 2004).

Prison Nurseries

According to a report by the American Medical Association (1997), the goals of prison nurseries are to enhance mother-child bonding and improve parenting skills. Child development experts stress the importance of the child's first year of life, when the foundation for intellectual, emotional, and social qualities is developed (American Medical Association, 1997). During this time, attachment to the primary caregiver is established. It is believed that, by addressing the factors of substance abuse and parenting skills, incarcerated mothers will be better able to provide stable and safe environments for their children when they are released (American Medical Association, 1997).

As noted in the report by the American Medical Association (1997), only New York, Nebraska, and Massachusetts operate long-term prison nurseries, which allow children to stay with their mothers from birth to 12 or 18 months of age. Many states, though, provide interim prison nurseries, allowing infants to remain with their mothers for up to 6 weeks. Nursery staff make sure the children have sufficient and appropriate food, clothing, medical attention, social stimulation, and contact with their mother.

The Titus 2 Birthing Program

Kathy Rateliff (2004) read online about the experience of a doula providing labor support to a prison inmate in Colorado. Consequently, in 1998, Rateliff developed a program in Fort Worth, Texas, that

provides incarcerated women with childbirth education classes, doula support, and parenting classes. She collaborated with the county sheriff, the prison chaplain, and other jail staff personnel and, in 6 weeks, began the Titus 2 Birthing program. Prenatal classes were held in the prison, with inmates receiving handouts and access to a lending library. *Lamaze Parents* magazine was one of the valued handouts. In 2001, the Titus 2 Birthing program started parenting classes in prisons. Soon after, the Child Protective Services Division of the Texas Department of Family and Protective Services began to accept class attendance as part of mandated parenting education for incarcerated mothers. In 2004, Rateliff reported the Fort Worth Titus 2 Birthing program had worked with over 750 incarcerated women and their families.

Mothers and Infants Nurturing Together Program

The Mothers and Infants Nurturing Together (MINT) program—also known as "Mothers With Infants Together" program—was created by the Volunteers of America in 1994 in Fort Worth, Texas (U.S. Department of Justice, Office of Justice Programs, 1998). Currently, nationwide MINT programs offer an alternative, residential inmate program for minimum-security women who are pregnant at the time of sentencing (U.S. Department of Justice, Federal Bureau of Prisons, 2007). Eligible women enter the MINT program during their last 3 months of pregnancy. After giving birth, the mother is allowed 3 months with her child to form a bond and, then, is returned to an institution to complete her sentence. The MINT program provides incarcerated mothers prenatal and postnatal classes that address childbirth, parenting, and coping skills and, in addition, offers counseling and treatment programs on chemical dependency, physical and sexual abuse, and vocational and educational opportunities (U.S. Department of Justice, Federal Bureau of Prisons, 2007).

IMPLICATIONS FOR CHILDBIRTH EDUCATORS

Childbirth and parenting education is one of the oldest and most elaborate forms of health promotion. Women and men who attend Lamaze classes for information and support learn more than the processes of labor and birth. They communicate with their developing infant, change unhealthy lifestyle practices to facilitate a healthy family, develop communication and negotiation skills for brighter futures, and learn to trust their own wisdom in giving birth and parenting. They develop support systems to ensure a peaceful birth and to share their experiences in the confusing world of parenting. Providing childbirth and parenting education to pregnant, incarcerated women and their partners is needed to help offer a positive future for this high-risk population and their infants.

Lamaze Certified Childbirth Educators (LCCE educators) are uniquely equipped to become change agents in the care of pregnant, incarcerated women. Collectively, LCCE educators are more than mere birth educators. They are trained in breastfeeding support, birth and postpartum doula support, and parenting education. They include stay-at-home mothers, volunteers in their communities, schoolteachers, professionals in business and law, physical therapists, social workers, graduate students, professors, nurses, midwives, and physicians. Many times, LCCE educators wear two or more of these hats. They have political and professional connections to help provide desperately needed services to pregnant women in juvenile centers, local jails, and state and federal prisons.

Many LCCE educators also provide birth and postpartum support as doulas. Woman-to-woman care in birth and postpartum has existed for over 3,000 years. Numerous studies have shown that continuous one-to-one support by a doula or other labor-support professional during labor and birth has a positive effect on birth outcomes and maternal-infant bonding (see Green, Amis, & Hotelling, 2007; Leslie & Storton, 2007). Considering the increased risk for pregnant women in jail, doula support has the potential to improve health outcomes and reduce costs for an exceptionally vulnerable group of mothers and babies (Schroeder & Bell, 2005).

With all of their skills and talents, LCCE educators, health-care providers, and parents are encouraged to initiate collaborative programs that improve the penal system's care for pregnant, incarcerated women and their infants (see the Box for helpful resources). Such efforts may help break the cycle of continued substance abuse, victimization of mothers and infants, and detached parenting and, thus, prevent a new generation of prison inmates.

Providing childbirth and parenting education to pregnant, incarcerated women and their partners is needed to help offer a positive future for this high-risk population and their infants.

BOX

Additional Resources for Lamaze Educators and Doulas Working With Pregnant, Incarcerated Women

As described in this article and substantiated throughout the literature, mothers and pregnant women who are incarcerated represent a vulnerable population with specific needs. It is also well recognized that, when mothers are incarcerated, the family network is damaged or destroyed. Providing adequate care for imprisoned mothers is an important factor in helping improve the health of American families, as mandated in *Healthy People 2010*:

> *The health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the U.S. population and as a predictor of the health of the next generation.**

Lamaze educators and doulas are important sources of support, education, and information for pregnant women and new mothers, wherever they may reside. Three of the model programs for incarcerated mothers described in this article are based on doula support, and all of the programs offer education that Lamaze educators are equipped to provide. Each program exists because someone was moved by the challenges that incarcerated pregnant women and mothers face and made a commitment to act.

You, too, can help improve the mental and physical health of this vulnerable population and, in turn, the overall health of America's families. The following organizations and their Web sites can assist you in your effort. Some of these resources provide information you will need to establish programs or to specifically address the challenges faced by incarcerated mothers; other resources offer funding opportunities.

Information:

- **National Commission on Correctional Health Care**
  Chicago, IL – Phone: (773) 880-1460 – Web site: www.ncchc.org
  Especially helpful: The organization's position statement, ''Women's Health Care in Correctional Settings'' (http://www.ncchc.org/resources/statements/womenshealth2005.html)
- **Our Bodies Ourselves**
  Boston, MA – Phone: (617) 451-3666 – Web site: www.ourbodiesourselves.org
  Especially helpful: ''Organizing for Change – Women's Anti-Prison Activism'' (http://www.ourbodiesourselves.org/book/companion.asp?id=32&compID=108)
- **Stop Prisoner Rape**
  Los Angeles, CA – Phone: (213) 384-1400 – Web site: www.spr.org
- **Legal Services for Prisoners with Children**
  San Francisco, CA – Phone: (415) 255-7036 – Web site: www.prisonerswithchildren.org
- **The Center for Young Women's Development**
  San Francisco, CA – (415) 703-8800
  Especially helpful: The organization's Girls Detention Advocacy Project (http://www.cywd.org/gdap.html)

Funding Opportunities:

- **Robert Wood Johnson Foundation**
  Princeton, NJ – Phone: (877) 843-7953 – Web site: www.rwjf.org
  Especially helpful: The organization awarded a 4-year grant for a Philadelphia study on improving the health and parenting skills of incarcerated, pregnant and postpartum women and their babies (http://www.rwjf.org/programareas/grant.jsp?id=58037&pid=1144&gsa=1)
- **March of Dimes**
  Web site: www.marchofdimes.com
- **Center for Substance Abuse Prevention**
  Substance Abuse and Mental Health Services Administration
  U.S. Department of Health and Human Services
  Maryland – Phone (240) 276-2420 – Web site: http://prevention.samhsa.gov/

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